STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155530	B. WINC			05/09/2	011
NAME OF I	DOVIDED OD GUDDI IED		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER			353 TYI	LER ST		
SOUTH	SHORE HEALTH &	REHABILITATION		GARY,	IN46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENC!)		DATE
K0000							
	A Life Safety	Code Recertification	K0	000			
	_	nsure Survey was					
		the Indiana State					
		Health in accordance					
	*						
	with 42 CFR 4	183.70(a).					
	_						
	Survey Date:	05/09/11					
	Facility Numb	er: 000369					
	Provider Num	ber: 155530					
	AIM Number:	100275190					
	Surveyor: Ric	chard D. Schade, Life					
	Safety Code S						
	Safety Code S	pecialist					
	At this Life Co	ifety Code survey,					
		3					
	South Shore H						
		was found not in					
	compliance wi	ith Requirements for					
	Participation in	n					
	Medicare/Med						
		0(a), Life Safety from					
	•	000 edition of the					
	National Fire I						
		NFPA) 101, Life					
		LSC), Chapter 19,					
	Existing Healt	h Care Occupancies					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FJDM21

Facility ID:

000369

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		(X2) MULTIPLE CC A. BUILDING B. WING	01	COM	(X3) DATE SURVEY COMPLETED 05/09/2011	
	PROVIDER OR SUPPLIER SHORE HEALTH &		353 TY	ADDRESS, CITY, STATE, ZIP LER ST IN46402	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
IAU	and 410 IAC I This one story basement was Type II (222) of fully sprinkler fire alarm syst detection in the spaces open to facility has a calculate a census of 78 survey. Quality Review by Safety Code Special 05/13/11. The facility we compliance we aforementione	facility with a partial determined to be of construction and was ed. The facility has a sem with smoke e corridors and the corridors. The capacity of 98 and had at the time of this Robert Booher, REHS, Life list-Medical Surveyor on as found not in ith the	IAG			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE (COMPL 05/09/2	ETED	
SOUTH	PROVIDER OR SUPPLIER	REHABILITATION		353 TYL GARY, II			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) TAG		Έ	(X5) COMPLETION DATE
K0018 SS=E	Doors protecting of than required enclexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6. Roller latches are regulations in all h Based on obseinterview, the ensure 6 of modors were freto closing. The affects resident in the resident compartments Findings Inclusion Based on obseinterview, the ensure 6 of modors were freto closing. The affects resident in the resident compartments Findings Inclusion Based on obseinterview, the ensure 6 of modors were freto closing. The affects resident compartments Findings Inclusion Based on obseinterview, the patient rooms 406 and 507 were for the patient rooms 406 and	orridor openings in other osures of vertical openings, areas are substantial se constructed of 1¾ inch wood, or capable of least 20 minutes. Doors in gs are only required to of smoke. There is no closing of the doors. Doors a means suitable for closed. Dutch doors are permitted. 19.3.6.3 prohibited by CMS ealth care facilities. rvation and facility failed to ore than 100 corridor e from impediments is deficient practice ts, staff and visitors room smoke on Units 3, 4 and 5.	K	0018	K018 All residentt privacy curttains were removed ftrom blockin the doors enttering the ma corridors. All residentts have the pottenttal tto be aftected this deftcientt practtceAll sti will be inserviced on the best practtce oft ensuring that a curttains are nott blocking the residentt doors ftrom closing and/or obstructtng Addittonally, the Mainttenan Directtor will conductt daily rounds ftor the weekswhich shall be deftned as 10 days) and all issues addressed immediattely through correctton, thraining and/or discipline oft personnel responsible, and nottftying the	g in ed by eaft stt II he	06/07/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CON	NSTRUCTION 01	(X3) DATE S COMPL		
ANDIEM	or connection	155530	A. BUILI		01	05/09/2	
			B. WING	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			353 TYL			
SOUTH S	SHORE HEALTH &	REHABILITATION		GARY, II	N46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	maintenance s				administtrattor All resultts of	t	
		at the time of the			tthis auditt will be submitted	tto	
		ne resident room			tthe qualitty assurance		
		ocked from closing.			committee ftor review and		
	doors were ore	oned from crossing.			processing.		
	3.1-19(b)				Responsible ftor Completton		
	3.1 17(0)				Mainttenance Directtor and	r	
					Designee		
					Datte oft ComplettαnJune 7, 2011		
					2011		
K0027	Door openings in s	smoke barriers have at least		1			
K0027 SS=F	a 20-minute fire pr						
		solid bonded wood core.					
	Non-rated protective plates that do not exceed 48 inches from the bottom of the door are						
	permitted. Horizon	ntal sliding doors comply					
		ors are self-closing or in accordance with					
		ing doors are not required					
	to swing with egre	ss and positive latching is					
	•	.3.7.5, 19.3.7.6, 19.3.7.7	 K00	27	V027		06/07/2011
	Based on obse		KU)2/	K027 The smoke barrier doors in		00/07/2011
	*	facility failed to			primary corridors ftor Unitt2		
		ets of smoke barrier			3, and 4 shall have closing	,	
	•	uipped with the			coordinattors insttalled by Ju	ne	
		rdware to allow the			7, 2011. All residentts have		
		ast close first, to			tthe pottenttal tto be aftectte	ed by	
		irst so both doors			tthis deftcientt practtceThe		
a	always close completely. CMS				mainttenance coordinattor w	/ill	
	requires smoke	e barrier doors			be responsible tto ensure tth	is	

		li ´		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155530	- 1	LDING	01	05/09/2011
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2011
NAME OF F	PROVIDER OR SUPPLIER			353 TYI		
	SHORE HEALTH &			1	IN46402	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		an astragal have a			is completted and tthen	
	coordinator to	ensure the door			monittor tto ensure complia	nce
	which must clo	ose first always			tthrough eftecttve operatton	
	closes first. T	his deficient practice			ftor ttwo week \$ which shall b	e
		l residents, staff and			deftned as 10 days) and	
	visitors.				submitt tthis compliance aud tto tthe qualitty assurance	iitt
					committee ftor review and	
	Findings inclu	de:			processing. Afterwards, tthe	.
	\mathcal{E}				Mainttenance Directtor will a	
	Based on observations on 05/09/11				tthis tto his weekly rounds tt	o
		p.m. and 2:50 p.m.			ensure compliance.	
	-	enance supervisor,			Responsible ftor Completton	
		rier doors in the			Mainttenance Directtor and	r
		or to Units 2, 3 and			Designee	
	4, which swing	· ·			Datte oft ComplettonJune 7,	
		ed a coordinator to			2011	
		which must close				
	_	close first. Smoke				
		o Units 2 and 3 had				
	_	which was self				
	_	Jnit 4 smoke barrier				
		th one door blocking				
	the other from	~				
		upervisor stated at				
		observation, he was				
	not aware of the	ne problems.				
	3.1-19(b)					
	,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		(X2) MU A. BUII B. WING	DING	NSTRUCTION 01	(X3) DATE : COMPL 05/09/2	ETED	
	PROVIDER OR SUPPLIER			STREET A 353 TYL GARY, I			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0029 SS=E	fire-rated doors) of extinguishing systiand/or 19.3.5.4 prowers with the approve extinguishing systiane separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 Based on obseinterview, the ensure 6 of moreom doors second and later passage of sme practice could visitors and stand the kitcher Findings inclusion. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions. Findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings inclusions are self-closed and later passage of sme practice could visitors and stand the kitcher findings in cluster findings i	em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches if the door are permitted. Tryation and facility failed to one than 12 storage ring hazardous areas ched to prevent the oke. This deficient affect residents, aff in and near Unit 2 in. de: Tryations with the	K0	029	K029 All doors identtfted will have auttomattc door closers insttalled by June7, 2011. Al residentts have tthe pottent be aftectted by tthis deftcier practtce. Each door will be able tto lattch att tthis ttnæs well. The diettary manager and mainttenance directtor monittor tthese closers ftor tweeks (which shall be deftne as 10 days) and submitt tthis compliance auditt tto tthe qualitty assurance committee ftor review and processing Afterwards, tthe Mainttenant Coordinattor will add tto tthe preventtattve mainttenance tto check tthese areas ittems a weekly basis. Responsible ftor Complettor.	l cal tto out	06/07/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155530	A. BUIL		01	05/09/2011
		10000	B. WINC	_	DDRESS, CITY, STATE, ZIP CODE	00/00/2011
NAME OF P	ROVIDER OR SUPPLIER			353 TYLI		
SOUTH S	SHORE HEALTH &			GARY, IN		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		ally close and latch.			Mainttenance Directtor and	
	The door to the	e kitchen pantry			Diettary Manager(and/or	
	containing box	xes, plastics and			designees)	
	_	ducts and the door to			Datte oft ComplettαnJune 7,	
the kitchen clean supply room					2011	
	containing combustibles and					
cleaning supplies did not						
	automatically close and latch. The					
	maintenance supervisor					
		the problem areas at				
	the time of obs	•				
	the time of obs	sei vation.				
	3.1-19(b)					
K0044 SS=E	Horizontal exits, if with 7.2.4. 19.2.	used, are in accordance 2.5				
	Based on obse	rvation and	K0	044	K044	06/07/2011
	interview, the	facility failed to			The smoke barrier doors in	
	ensure 2 of 3 f	ire door sets were			primary corridors ftor Unitt®	,
	arranged to au	tomatically close and			3, and 4 shall have closing	
	latch. LSC sec				coordinattors insttalled by Ju	ne
	requires horizo	ontal exits to be in			7, 2011. All residentts have	and the co
	_	th 7.2.4 and 7.2.4.3.8			tthe pottenttal tto be aftectte	ea by
	requires fire de				tthis deftcientt practtceThe mainttenance coordinattor w	uill I
	•	omatic closing in			be responsible tto ensure tth	
	_	_			is completted and tthen	-
	accordance with 7.2.1.8. In addition NFPA 80, Standard for				monittor tto ensure compliar	nce
					tthrough eftecttve operatton	
		Fire Doors and Windows 2-1.4.1			ftor ttwo week which shall be	e
	requires all closing mechanisms				deftned as 10 days) and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ISTRUCTION 01	(X3) DATE S COMPL		
		155530	A. BUILD B. WING	ING		05/09/2	
NAME OF I	PROVIDER OR SUPPLIER	,		STREET AI	DDRESS, CITY, STATE, ZIP CODE		
				353 TYL			
	SHORE HEALTH &			GARY, IN	N46402		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	DI	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	shall be adjust	ted to overcome fire			submitt tthis compliance aud	litt	
	resistance of the	he latch mechanism			tto tthe qualitty assurance		
	so that positiv	e latching is achieved			committee ftor review and		
	on each door o	operation. This			processing. Afterwards, tthe		
	deficient pract	tice affects all			Mainttenance Directtor will a		
	residents, staff	f and visitors on and			tthis tto his weekly rounds to ensure compliance.	O	
	near the facilit	ty's Unit 2 and 3.			Responsible ftor Completton		
					Mainttenance Directtor and		
	Findings inclu	ıde:			Designee		
					Datte oft ComplettαnJune 7,		
	Based on obse	ervation and interview			2011		
	with the maint	tenance supervisor on					
		reen 2:15 p.m. and					
		fire doors to Units 2					
	•	close completely and					
		eaving a gap of					
		three feet. The					
		supervisor stated at					
	the time of ob	-					
		which should close					
	and latch the d	loors were broken.					
	3.1-19(b)						
	, ,						
K0048 SS=F		plan for the protection of all error error error.					
J .	of an emergency.	19.7.1.1		_			
	Based on reco		K00	48	K048		06/07/2011
	interview, the	facility failed to have			The ftacilitty hereby submitts	5	
					tthatt a ftull emergency		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530		LDING	ONSTRUCTION 01	(X3) DATE COMPI 05/09/2	LETED	
	PROVIDER OR SUPPLIE		 353 TYI	ADDRESS, CITY, STATE, ZIP CODE LER ST IN46402		
	SHORE HEALTH & SUMMARY S (EACH DEFICIENT REGULATORY OF 1 of 1 written occupancy firmincorporated in 101, Section 11. Use of alar 2. Transmissing department. 3. response to 4. Isolation of 5. Evacuation of 6. Evacuation compartment. 7. Preparation building for example 8. Extinguish This deficient residents, staff event of an enterprise of the second of the seco	REHABILITATION STATEMENT OF DEFICIENCIES RCY MUST BE PERCEDED BY FULL RESC IDENTIFYING INFORMATION) health care e safety plans that tems listed in NFPA 19.7.2.2., rms. on of alarms to fire o alarms. f fire. o fire. o of immediate area. o of smoke n of floors and vacuation. ment of fire. practice affects all ff and visitors in the nergency. ide: ord review, on 15 p.m. with the supervisor, the facility evidence of a complete care occupancy fire	353 TYI	LER ST	tted e cy tthe oy tthis all l on June ng eged vell	(X5) COMPLETION DATE
	Evacuation Po	procedure. The blicy did not contain residents being				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	01	li i	ESURVEY	
		155530	A. BUILDING B. WING		- 05/09/	
NAME OF F	AD CLUBED OD CLUBBLIED			ADDRESS, CITY, STATE, ZIP C	ODE	
	PROVIDER OR SUPPLIER			LER ST		
SOUTH	SHORE HEALTH &	REHABILITATION	GARY,	IN46402		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE ADEFICIENCY)		COMPLETION DATE
		red to a specific				J.K.E
	meeting area,	_				
	_	ained in specific				
	-	erformed in the event				
	_	on and preparations				
		e building. The				
		ted no policy or				
		ressing actions to be				
	•	icility in the event a				
	-	•				
	_	should occur since				
	the facility do					
	emergency ger					
		upervisor stated at				
		record review, he				
	_	olicies or procedures				
	to review unle					
		had them, but he was				
	in a meeting.					
	3.1-19(b)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		NSTRUCTION 01	COMPL	ETED	
		155530	B. WIN			05/09/2	011
	PROVIDER OR SUPPLIER			353 TYL	ADDRESS, CITY, STATE, ZIP CODE LER ST IN46402		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
K0050 SS=F	Fire drills are held varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent persons exercise leadershi conducted betwee announcement manudible alarms. Based on recording trills are drill quarterly on earliest 4 quarters, practice could staff and visitor emergency. Findings inclusions are drill recording to the third are 2010. There were that drills are drill are drill are drills are drill recording to the third are 2010.	at unexpected times under at least quarterly on each amiliar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 and review and facility failed to ach shift for 3 of the This deficient effect all patients, but in the event of an de: Ew of the facility's and interview on the p.m. with the appervisor, there was third shift fire drill and fourth quarters of was no evidence of g completed for the	KO	0050	K050 The Mainttenance Directtor received a tteachable mome relatted tto lack oft ftre drills being completted All residentts have tthe pottent be aftectted by tthis deftcier practtce. A complette ftre dischedule has been drafted—in accordance witth tthe sttrattegic varied ttmes ftor shifts—and will be putt in place eftecttve June 7, 2011. Any variance tto tthis schedulity assurance committed will be addressed in tthe qualitty assurance committed meeting. Addittonally, all personnel will be rettrained ftre preparedness and disast planning policies prior tto Ju 7, 2011. Responsible ftor Complettor.	antt stal tto att rill e on ter ne	06/07/2011
maintenance supervisor			Mainttenance Directtor and)r			
		•			Designee		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CON	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155530	A. BUIL		01	05/09/2	
		10000	B. WING		DDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF P	ROVIDER OR SUPPLIER			353 TYL			
	SHORE HEALTH &			GARY, II			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG			COMPLETION DATE
		fire drills were not			Datte oft ComplettonJune 7,		
	conducted dur	ing the first quarter			2011		
	of 2011 and th	ird shift drills were					
	not completed	for the last two					
	quarters of 201	10.					
	•						
	3.1-9(b)						
	3.1-51(c)						
K0052		n required for life safety is					
SS=F	installed, tested, a accordance with N	nd maintained in IFPA 70 National Electrical					
	Code and NFPA 7	2. The system has an					
	* *	ance and testing program plicable requirements of					
	NFPA 70 and 72.						
	Based on inter	view and record	K0	0052	K052		06/07/2011
	review, the fac	cility failed to provide			The ftre alarm systtem will be	e	
	evidence of the	e testing,			inspectted by June7, 2011. A	All .	
		nd inspection of 1 of			residentts have tthe pottentt		
		stems. LSC 9.6.1.4			be aftectted by tthis deftcien	tt	
	•	72, National Fire			practice. The mainttenance		
		NFPA 72, 7-1.1.1			coordinattor has received a tteachable momentt relatted	l #o	
		arm systems shall be			tthis deftcientt practice and	itto	
	-	ed and maintained.			now has tthis ittem 'ttcklered	d '	
	NFPA 72, 7-5.				ftor yearly review The		
	inspection, tes	-			inspectton reportt will be		
	-	-			submitted tto tthe qualitty		
	maintenance records shall be provided. This deficient practice effects all residents, staff and			assurance committee, nottes	;		
				only, and notted by			
	effects all resid	dents, starr and			administtrattor All inspectton	ns	

	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CON	STRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING	j.	01	COMPL		
		155530		B. WING			05/09/2	UII	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
SUITU	SHORE HEALTH &	REHARII ITATION			3 TYLE	ER ST 146402			
						110704		075	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREF	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	DATE	
	visitors in the	event of an				oft tthis ttype will ttake place	att		
	emergency.					tthe correctt inttervals going			
						ftorward tthrough tthe remir	nder		
	 Findings inclu	de·				calendar, as completted by t	the		
		· · · · ·				Mainttenance Directtor			
	During record	review for the fire				Responsible ftor Completton			
	-	review for the fire				Mainttenance Directtor and	r		
	1	inspections with the				Designee			
	maintenance s	=				Datte oft ComplettonJune 7,			
	05/09/11 at 1:5	-				2011			
		n of records of the							
	·	intenance and testing							
		m system could not							
	be found. The	maintenance							
	supervisor stat	ted at the time of							
	record review,								
		f an alarm inspection							
	being complet	•							
	1 .	vidence to provide.							
	documentou e	ridefice to provide.							
	3 1 10/b)								
	3.1-19(b)								
K0054	All required smoke	e detectors, including those							
SS=F		ld-open devices, are							
		ned, inspected and tested in							
	accordance with the specifications.	he manufacturer's 9.6.1.3							
	Based on reco			K0054	.	K054		06/07/2011	
		facility failed to				The smoke dettecttor systter	n		
DCD-:						<u> </u>		,	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	FJI	DM21 F	acility ID	c: 000369 If continuation sl	neet Pac	ge 13 of 24	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 01	(X3) DATE S COMPLI		
		155530	A. BUI B. WIN	LDING JG		05/09/20	
NAME OF I	PROVIDER OR SUPPLIEI	<u> </u>	D. 1111		ADDRESS, CITY, STATE, ZIP CODE	l .	
			353 TYLER ST				
	SHORE HEALTH &				IN46402		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	provide writte	n documentation 1 of			will be inspectted by June7,		
	1 smoke detec	etion systems had			2011. All residentts have tth	e	
	been tested to	ensure the detectors			pottenttal tto be aftectted by	/ tthis	
	were within th	nere listed and marked			deftcientt practtce The		
	sensitivity ran	ge. LSC Section			mainttenance coordinattor h		
		ne provisions of 9.6			received a tteachable mome relatted tto tthis deftcientt	ntt	
	1	c functions of the fire			practice and now has tthis it	tem	
	alarm system,	including fire			'ttcklered' ftor yearly review		
	1	ems. LSC 9.6.1.4			The inspectton reportt will b		
	1	A 72, National Fire			submitted tto tthe qualitty		
		NFPA 72, 7-3.2.1			assurance committee, nottes	5	
		tor sensitivity shall be			only, and notted by		
	1 '	n one year after			administtrattor All inspecttor		
		d every alternative			oft tthis ttype will ttake place		
		r. After the second			tthe correctt inttervals going ftorward tthrough tthe reminer		
	required calib				calendar, as completted by t		
	sensitivity tes	· ·			Mainttenance Directtor		
		e remained within			Responsible ftor Completton	·	
	their listed and	d marked sensitivity			Mainttenance Directtor and	r	
		ngth of time between			Designee		
	_	ts may be extended to			Datte oft ComplettonJune 7,		
		f five years. If the			2011		
		xtended, records of					
		ed nuisance alarms					
	shall be maint	ained. In zones or					
	areas where n	uisance alarms show					
		over the previous year,					
		ts shall be performed.					
		h smoke detector is					

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION (XA) ID PREETX TAG Within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided for the owner or a designated		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	A. BUI	LDING	NSTRUCTION 01	<u>`</u>	e survey Pleted /2011
SUMMARY STATEMENT OF DEFICIENCIES PREFIX CEACH DEFICIENCY MUST BE PERCEDED BY FULL PROVIDED STANDON SHORDED BY FULL TAG Within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity range. (5) Other calibrated sensitivity test method acceptable sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided				B. WIN	STREET A	ER ST		
### RECULATORY OR LSC IDENTIFYING INFORMATION within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided					<u> </u>	N404U2		
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Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		method accept	able to the authority					
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sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		Detectors foun	nd to have sensitivity					
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detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		sensitivity rang	ge shall be cleaned					
tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		and recalibrate	ed or replaced. The					
that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		detector sensit	ivity shall not be					
concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		tested or meas	ured using any device					
detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided		that administer	rs an unmeasured					
that inspection, testing and maintenance reports be provided		concentration	of aerosol into the					
that inspection, testing and maintenance reports be provided		detector. NFP	A 72, 7-5.2 requires					
maintenance reports be provided			-					
		•	•					
0			-					
representative. It shall be the								

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION (X4) ID SUMMARY STATEMENT OF DEEDCIENCES TAG REQUILATION (SEE DEEDLY SHOP BE PEACEDED BY FILL) TAG REPORT SHOP BEACED TO BE STORY FOR THE PROPERSON (SEE DEEDLY SHOP BE PEACEDED BY FILL) TAG REPORT SHOP BEACEDED TO BE STORY FOR THE PROPERSON CORN FILL) TAG REPORT SHOP BEACEDED TO BE STORY FOR THE PROPERSON		T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530		LDING	NSTRUCTION 01	COM	E SURVEY PLETED //2011
PREFIX TAG RECULDEFICENCY MUST BE PERCEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATIONS) responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could effect all occupants in the facility including residents, staff, and visitors. Findings include: Based on review of the maintenance records on 05/09/11 at 1:20 p.m. with the maintenance esupervisor, there was no written documentation available to show the smoke detectors in the facility had been tested for sensitivity. The maintenance supervisor acknowledged at the time of record review, he had no recollection of a smoke detector sensitivity test being completed and had no documented evidence to provide.				1	STREET A	ER ST	DDE	
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	IAU	responsibility maintain these of the system a available for e authority havin or electronic macceptable. The could effect all facility including and visitors. Findings inclusional Based on review maintenance reference of 1:20 p.m. with supervisor, the documentation the smoke detect had been tested maintenance is acknowledged review, he had smoke detectors being completed documented events.	of the owner to records for the life and to keep them xamination by the ng jurisdiction. Paper nedia shall be nis deficient practice I occupants in the ang residents, staff, de: we of the ecords on 05/09/11 at the maintenance are was no written a available to show ectors in the facility d for sensitivity. The upervisor at the time of record and recollection of a resnsitivity test ed and had no		IAU			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 01			(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155530	A. BUILDING			05/09/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			353 TYI			
SOUTH	SHORE HEALTH & I	REHABILITATION		GARY, I	IN46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
K0062 SS=E	Required automatic continuously mainted condition and are in periodically. 19: 25, 9.7.5 Based on obset interview, the ensure 6 of mosprinklers white corroded or load replaced. LSC automatic spring inspected, tested accordance with for the Inspect Maintenance of Protection System 1998 edition, 2 sprinkler shall painted, corrodoloaded, or in the orientation. The could effect the kitchen and resisting including the shall painted.	c sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA rvation and facility failed to ore than 175 ch were either aded with dirt were 2.9.7.5 requires all inkler systems shall be and maintained in the NFPA 25, Standard ion, Testing, and of Water-Based Fire tems. NFPA 25, 2-2.1.1 requires any be replaced which is ded, damaged, ine improper this deficient practice a staff in and near the sidents in the Beauty	K	0062	K062 The sprinkler heads identified will be replaced by June 7, 2011. The ftacilitty will likely an updatted sprinkler systter inspection att tithis same time. All residentts have tithe pottential to be aftected by deficient practice. The maintenance coordinattor with monittor sprinkler heads on montify basis and any variances to regulattory compliance will be addressed to tithe administrattor ftor immediatte response. Any variance will be addressed in tithe quality assurance committee meeting ftor reviand processing. Responsible ftor Complettom Maintenance Directtor and Designee Datte oft ComplettomJune 7, 2011	do m lee tthis vill a	06/07/2011

l	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	A. BUILD B. WING		01	COMPL 05/09/2	ETED
	PROVIDER OR SUPPLIER			STREET A 353 TYL GARY, II		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with the maint 05/09/11 betw 3:20 p.m., the sprinklers in the loaded with distairwell to the in the Beauty to the maintenant at the time of the stairwell to the control of the maintenant at the time of the stairwell to the stai	enance supervisor on een 2:25 p.m. and four automatic ne kitchen were rt, the sprinkler in the e partial basement and Shop were corroded. Ince supervisor stated the observation, he of the problem.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530		(X2) MUL A. BUILD B. WING		01	(X3) DATE S COMPL 05/09/2	ETED
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & F	REHABILITATION		STREET AD 353 TYLE GARY, IN			
PREFIX (EACH DEFICIENC TAG REGULATORY OR I	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	- 1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
(1) Smoking is profor compartment who combustible gases, stored and in any cand such area is possible for no smoking by pattersponsible is prohibited in the profession. (2) Smoking by pattersponsible is prohibited in the profession. (3) Ashtrays of none safe design are prosmoking is permitted. (4) Metal container devices into which are readily available smoking is permitted. Based on record observation and facility failed to smoking regulate to protect 98 of deficient practice residents, staff near the smoking. Findings include Based on review.	nibited in any room, ward, were flammable liquids, or oxygen is used or ther hazardous location, osted with signs that read with the international king. ients classified as not libited, except when under combustible material and ovided in all areas where ed. s with self-closing cover ashtrays can be emptied to all areas where ed. 19.7.4 d review, d interview; the provide written ations for employees for provide written and ovided effect and visitors in and ang areas.	K00	066	K066 The ftacilitty has drafted a nepolicy and procedure ftor smoking on the premises Al residentts have the pottent be aftectted by this deftcien practice. All employees will be inserviced on this policy and procedure during an all-sttaft meeting prior tto Ju 7, 2011. All residentts currently have a policy and procedure in place ftor smoking on the premises and this policy will be reviewed.	II aal tto itt ine	06/07/2011

PRINTED: 06/03/2011 FORM APPROVED OMB NO. 0938-0391

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		353 TY	ADDRESS, CITY, STATE, ZIP CO LER ST IN46402	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ST CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE IPPROPRIATE	(X5) COMPLETION DATE
	maintenance s had no written policy or proc observations d maintenance s 05/09/11 betw 3:20 p.m., emp observed smol building and th supervisor stat observation, stat allowed in the maintenance s	een 2:25 p.m. and ployees were king outside of the he maintenance ted at the time of moking was not building. The upervisor the lack of a policy		witth tthe social servidirecttor and tthen as copy oft such inftorm be provided tto resid ftamilies. The ftacilitismonittor compliance deficient practice till weekly rounds by till mainttenance directit quartterly review oft by till quality assur committee. Responsible ftor Committee Directit Services Direction and Administiration (and/or Designees) Datte oft Complettom 2011	n updatted natton will entts and y will oft tthis hrough e or and tthis policy rance hpletton torSocial d	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		A. BUII	LDING	nstruction 01	(X3) DATE S COMPL 05/09/2	ETED	
		155550	B. WIN		DDDEGG GIEW GELTE ZID GODE	03/03/2	011
NAME OF I	PROVIDER OR SUPPLIER			353 TYL	DDRESS, CITY, STATE, ZIP CODE FR ST		
	SHORE HEALTH &			GARY, I			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
K0074 SS=E	Draperies, curtains and other loosely serving as furnishicare occupancies provisions of 10.3. for the Installation Shower curtains a 701. Newly introduced health care occupa specified when tes methods cited in 119.7.5.1, NFPA 13 Newly introduced specified when tes method cited in 10 Based on obseinterview, the protect 98 of 9 ensuring all drivalances serving were flame resident to 10 practice could and visitors in near Unit 2. Findings inclusions and other protect of the protect	mattresses meet the criteria sted in accordance with the 0.3.2 (3), 10.3.4. 19.7.5.3 rvation and facility failed to 0.8 residents by aperies, curtains and ng as furnishings sistant in accordance 0.1. This deficient affect residents, staff the main corridor	K	0074		n nay utt ory	DATE 06/07/2011

PRINTED: 06/03/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	A. BUIL B. WING	DING	01	(X3) DATE S COMPL 05/09/20	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN46402				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	drape with no documentation being treated with maintenar acknowledged observation, he evidence of firm	of fire resistance or with a fire retardant. ace supervisor at the time of			variance tto tthis will be correctted immediattely and tthe administrattor will be nottfted. Addittonally, tthese issues will be submitted tto t qualitty assurance committed ftor review and processing Responsible ftor Completton Mainttenance Directtor and Designee Datte oft ComplettonJune 7, 2011	e the e	
K0076 SS=E	are protected in ac Standards for Hea (a) Oxygen storage 3,000 cu.ft. are en separation. (b) Locations for se than 3,000 cu.ft. at NFPA 99 4.3.1.1.2	e locations of greater than closed by a one-hour upply systems of greater re vented to the outside.					
	facility failed to oxygen storage with signage in	rd review, d interview; the so ensure 1 of 1 e areas was provided adicating the storage smoking was not	K0	076	K076 Please see plan oft correctto ftor K066 relatted tto tthe smoking policy. All residentt have tthe pottenttal tto be aftectted by tthis deftcientt practice. As ftor tthe oxygen	s	06/07/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FJDM21 Facility ID:

000369

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED
		155530	B. WIN			05/09/2011
NAME OF B	DROVIDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF P	PROVIDER OR SUPPLIEF			353 TY	LER ST	
	SHORE HEALTH &	REHABILITATION		GARY,	IN46402	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		,	•	TAG		DATE
	_	is deficient practice			room, an identtftying sign	
	could affect st	aff in and near the			indicattng tthe room is an	
	oxygen storag	e room.			oxygen room has been	
					insttalled Near tthis sign,tthe	ere
	Findings inclu	de·			is a sign indicattng	
		· · · ·			no-smoking. All sttaft will be	
	Danad - : -1	4::41. 41			nottfted aboutt tthis deftcier	ntt
		ervation with the			practtce during an all sttaft	
		upervisor during the			meettng prior tto June7,	
	tour of the fac	ility at 3:15 p.m. on			2011. The housekeeping	
	05/09/11, the 1	facility's oxygen			directtor will monittor tthis	
	storage room	was not provided with			posttng on a daily basis tto	
	_	ng the storage of			ensure tthatt tthe nottftcatto	on is
	_				sttll presentt(ftor10 days). Th	nis
		ying smoking was			auditt shall be submitted tto	
		Based on review of			tthe qualitty assurance	
	the facility's p	olicy and procedure			committee meettng ftor revi	ew
	manual on 05/	09/11 at 2:20 p.m.			and processing.	
	with the maint	enance supervisor,			Responsible ftor Complettor.	n
		d no written employee			Housekeeping Directtor an⊄	or
	1	y or procedure. The			Designee	
		•			Datte oft ComplettonJune 7,	
	maintenance s	1			2011	
	_	at the time of				
	observation, th	ne oxygen storage				
	room had no s	ign indicating the				
		gen in the room and				
		was not permitted.				
	liat sillokilig	mus not pormitted.				
	2.1.10(1)					
	3.1-19(b)					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	01	l l	E SURVEY PLETED (2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN46402						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE			